CONFIDENTIAL HEALTH RECORD

LAST NAME	FIRST NAME MIDDLE INITIAL (NICKNAME)	☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ REVEREND ☐ SISTER ☐ FATHER
HOME ADDRESS	CITY STATE ZIP	
SOCIAL SEC #	BIRTHDATE	EMPLOYER_____ ADDRESS _____
HOME PHONE # ( )	WORK PHONE # ( ) EXT#	CELL PHONE# ( )
SPOUSE NAME	IF CHILD, PARENT'S NAME_____ IF STUDENT, SCHOOL_____ CITY_____	
YOUR GENERAL DENTIST	WHO REFERRED YOU TO OUR OFFICE:	
DENTAL COVERAGE ☐ YES ☐ NO COMPANY NAME _____ ADDRESS_____ _____ GROUP # _____	NAME OF INSURED_____ RELATION_____ INSURED'S SS#_____ BIRTHDATE_____ INSURED'S EMPLOYER_____	

INFORMATION SHEET AND STATEMENT OF OFFICE POLICY

You have been referred to our office for root canal examination, consultation, and treatment as deemed necessary. In order to serve you better and a rrive at a mutually beneficial understanding of your treatment, it is important for you to read and understand the following:

Endodontics is a specialty whose purpose is to relieve pain, eliminate infection and **SAVE TEETH**. Many years of experience and study, including additional training following dental school are required for one to become an endodontist.

Most of our treatment procedures require one or two office visits, then **you will return to your dentist for placement of a final restoration on the tooth.** Our fees will vary depending on the time involved, the difficulty of treatment and the number of root canals contained within the tooth.

In our office we all feel a great deal of responsibility to our patients and strive to do the best work we are capable of doing in serving you. We have, unfortunately, not had a similar response from some of our patients in regards to payment to us for services rendered. We therefore have had no choice but to insist on a full payment by completion of treatment. Should you have dental insurance coverage, we will gladly submit those forms for you and request only a partial payment from you personally on your final visit. We want to emphasize that your insurance is a contract between you and your insurance company, not your insurance company and our office.

Your signature below hereby authorizes our office to affix your name to any and all claims or documents as related to any and all health benefits due for treatment rendered in this office. When necessary, payment due will be directly made to this office. Please review the copy of this office's Notice of Privacy Practices located in the waiting room. Copies will be made available upon request. Signing this form will give consent to use and disclose your protected health inform ation to carry out treatment, payment activities and healthcare operations.

I HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____ _____

Date Signature of Patient *

All signatures must be by parent or guardian if patient is under the age of 18.

PLEASE COMPLETE BOTH SIDES

MEDICAL HISTORY

Physician's name_____
Physician's phone (if known)_____
Has there been any change in your general health within the past year? ☐ YES ☐ NO
Please specify_____
Are you currently under the care of a physician? ☐ YES ☐ NO
Please explain_____
Have you been hospitalized within the past five years? ☐ YES ☐ NO
Reason_____
Are you taking any prescription / over the counter drugs? ☐ YES ☐ NO
Please list_____ _____
_____ _____
_____ _____
Due to health reasons do you take antibiotics before dental treatment? ☐ YES ☐ NO
Have you ever experienced pain / discomfort in your jaw joint (TMJ)? ☐ YES ☐ NO

Please check if are you ALLERGIC to any of the following?

☐ Aspirin	☐ Penicillin	☐ Tetracycline
☐ Codeine	☐ Clindamycin	☐ Sulfa Drugs
☐ Dental Anesthetics	☐ Erythromycin	☐ Latex

Please list any other drugs/materials you are allergic to: _____

Have you ever had any of the following diseases or medical problems?
(PLEASE CHECK)

☐ Abnormal Bleeding	☐ Diabetes	☐ Heart Surgery	☐ Radiation Treatment
☐ Alcohol/Drug Abuse	☐ Difficulty Breathing	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Emphysema	☐ Herpes/Fever Blisters	☐ Shingles
☐ Arthritis	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Artificial Bones/Joints/Valve	☐ Fainting Spells	☐ HIV+/AIDS	☐ Sinus Problems
☐ Asthma	☐ Frequent Headaches	☐ Kidney Problems	☐ Stroke
☐ Blood Transfusion	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Problems
☐ Cancer/Chemotherapy	☐ Hay Fever	☐ Low Blood Pressure	☐ Tuberculosis
☐ Colitis	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Pacemaker	☐ Venereal Disease

WOMEN ONLY:
Are you pregnant? ☐ YES ☐ NO
Are you nursing? ☐ YES ☐ NO
Do you take birth control pills? ☐ YES ☐ NO
(*If yes, be advised that if you take antibiotics, an alternative method birth control must be used)*

FEE MUST BE PAID IN FULL AT THE COMPLETION OF TREATMENT.
WHICH OF THE FOLLOWING METHOD OF PAYMENT WILL YOU BE USING?

☐ CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN GENERAL OR CARE CREDIT

Office Use Only **MEDICAL HISTORY UPDATE**
Date_____Signature_____Comments_____
Date_____Signature_____Comments_____